# Maricopa Senior Select Plan

Medicare is the nation's largest insurer of health care benefits. MIHS-HP contracts with the Center for Medicare and Medicaid Services (CMS) as Maricopa Senior Select Plan (MSSP), a Medicare plus Choice (M+C) plan. As its name implies, the primary goal of the M+C program is to provide Medicare beneficiaries with a wider range of health plan choices to complement the original Medicare option. Program Contractors like Maricopa Integrated Health Systems Health Plans (MIHS-HP) who administer Medicare Plus Choice plans are required by CMS to comply with all rules and regulations of the Medicare program. Our contracted physicians must also comply with these requirements.

## New Rules for When and How Often Medicare Eligibles May Switch Plans

Over the next two years, the rules for when and how often Medicare eligibles can switch Medicare health plans will change. If you have a patient in a Medicare health plan or thinking about joining one, you need to know how the new rules will affect him/her. The new rules are:

**Starting January 1, 2002,** Medicare beneficiaries can leave a Medicare health plan and join another plan **only one time** from **January 1** through **June 30, 2002**. The plan must be accepting new members.

**In November of 2002**, Medicare beneficiaries will have another chance to switch plans. If a plan is switched in November 2002, the change will be effective January 1, 2003.

**Starting January 1, 2003,** the rules will change. Beneficiaries can leave a Medicare health plan and join another plan **only one time** from **January 1** through **March 31, 2003**. The plan must be accepting new members.

Just like in 2002, beneficiaries will have another chance to switch plans in **November**. Any change made in November will be effective the following January.

There are some exceptions to these new rules. There are a few times when the new rules for the year 2002 and beyond do not apply. Beneficiaries may leave or join a Medicare health plan at another time if:

1. The beneficiary's health plan leaves Medicare.
2. The beneficiary moves out of their plan's service area.
3. The beneficiary is in another situation that Medicare decides is an exception.
4. The beneficiary is 65 years old and new to Medicare.
5. The beneficiary just became eligible to join a Medicare managed care plan, or Private Fee-for-Service plan.

Additional exceptions, as determined by CMS, may apply. Please instruct you members to contact the Customer Services Department at 602-344-8760 with any questions about eligibility.

# Maricopa Senior Select Plan continued

## Covered Services

MSSP includes a wide variety of services in its benefit package. They include but are not limited to:

Hospital Services
Out Patient Substance Abuse
Urgent Care
Prosthetic Devices
Manual Manipulation of the Spine
Physical & Speech Therapy
Annual Health Screening
Colorectal Screening Exams
Pneumococcal Immunizations
Out Patient Prescription Drugs
Physician Services
Out Patient Surgery
Durable Medical Equipment
Medical Supplies
Podiatric Care
Skilled Nursing Facility
Pap Smears & Pelvic Exams
Prostrate Cancer Screens
Flu Immunizations
Out Patient Mental Health
Emergency Care
Ambulance Services
Xrays and Laboratory
Out Patient Rehabilitation
Home Health Care
Bone Mass Measurements
Diabetic Monitoring
Hepatitis B vaccine

### Service Area Disenrollment

MSSP must disenroll an individual who moves out of MSSP service area (Maricopa County) after MSSP receives written verification from the member that the individual has moved out of the service area, or the member has been outside of the service area for more than six months.

### Quality Management

MIHS-HP contracted providers agree to participate in MSSP quality improvement processes. Quality Management includes credentialing, recredentialing, facility audits and active participation in surveys. Please direct any concerns regarding quality to the MSSP Quality Management Department. MSSP will investigate quality issues.

## Formulary

MSSP has a closed formulary and expects its physicians to use the drugs listed on its formulary. Should a formulary drug not be appropriate for your member, please request a non- formulary drug via fax on the Non Formulary request form. This form is located in your Provider Manual in the section titled forms and on the Internet at our website http://mihs.Maricopa.gov.

## Supply Formulary

MSSP has a supply formulary and expects that its physicians will use the supplies on its formulary. Private practice physicians will forward all supply requests via fax to MIHS-HP Medical Management. Family Health Center, Comprehensive Health Center and Maricopa Medical Center physicians will submit requests that DONOT require authorization to Materials Management via fax. Supplies that require authorization will be designated with an "**A**" immediately to the left. Requests that require authorization or that are not on the formulary will be faxed to MIHS-HP Medical Management with all supporting documentation.

## Hospital Notification

MSSP expects its contracted Hospitals to notify MSSP in accordance with the authorization requirements stated in their contract and as outlined in the Provider Manual. If a MSSP member's status is not determined at the time of admission, MSSP must be notified within 1 working day of the member's identification. If the member has been discharged and the member is still in the facility the notification must occur within 2 hours. If the member is no longer in the Contractors facility after identification occurs, the contractor must notify MSSP no later than 1 working day after the identification has been made.

The Contractor must provide a written explanation and documentation as to why the member could not be identified. If the explanation is not accepted by MSSP authorization will begin at the date of notification. An acceptable explanation will result in authorization beginning from the date of admission.

# Maricopa Senior Select Plan continued

## Prior Authorization

| Service or Procedure | Phone Number | Fax Number |
|---|---|---|
| | | |
| **After Hours Authorizations** | (602) 344-8111 | (602) 344-8524 |
| | | |
| **Hospitalization Requests/Notifications:**<br>Inpatient hospitalizations<br>Pre-admissions for elective surgery<br>Observation Unit | (602) 344-8734 | (602) 344-8348 |
| | | |
| **Outpatient services:**<br>Outside of the service area provider<br>Contracted provider | 602) 344-8483<br>(602) 344-8825<br>(602) 344-8310 | (602) 344-8706 |
| | | |
| **Skilled Nursing Facilities** | (602) 344-8734 | (602) 344-8348 |
| | | |
| **Rehabilitation** | (602) 344-8734 | (602) 344-8348 |
| | | |
| **OB Authorizations/Notifications:**<br>Delivery notifications<br>Prenatal care/global OB services | (602) 344-8111 | (602) 344-8524 |
| | | |
| **Pharmacy:**<br>Non-Formulary Drug Request<br>Drugs requiring prior authorization<br>Intravenous infusion (IV) non-formulary hydration<br>TPN (total parenteral nutrition) | (602) 344-8451 | (602) 344-8524 |
| | | |
| **Dental:**<br>Dental Evaluations | (602) 344-8111 | (602) 344-8524 |
| Dentures | (602) 344-8483<br>(602) 344-8825<br>(602) 344-8310 | (602) 344-8706 |
| | | |
| **Supplies/Equipment (DME):**<br>Durable Medical Equipment | (602) 344-8483<br>(602) 344-8825<br>(602) 344-8310 | (602) 344-8706 |
| Oxygen | (602) 344-8111 | (602) 344-8524 |
| Prosthetics, Orthotics, Braces | (602) 344-8483<br>(602) 344-8825<br>(602) 344-8310 | (602) 344-8706 |
| | | |
| **Home Care Services:**<br>Home Health Aid<br>Home Uterine Monitoring | (602) 344-8483<br>(602) 344-8825<br>(602) 344-8310 | (602) 344-8706 |
| Home Health Care (related to Hospital Discharge) | (602) 344-8734 | (602) 344-8348 |

# Maricopa Senior Select Plan continued

## Prior Authorization cont.

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|---|---|---|
| Home Health Nursing | (602) 344-8483<br>(602) 344-8825<br>(602) 344-8310 | (602) 344-8706 |
| **Other:** | | |
| Allergy consults & testing<br>(Outside of FHC's) | (602) 344-8483<br>(602) 344-8825<br>(602) 344-8310 | (602) 344-8706 |
| Dexa Scans | (602) 344-8111 | (602) 344-8458 |
| Dialysis | (602) 344-8111 | (602) 344-8458 |
| Dialysis – Out of Network | (602) 344-8111 | (602) 344-8458 |
| Disease Management Programs | (602) 344- 8926 (Asthma)<br>(602) 344- 8930 (CHF)<br>(602) 344- 8814 (Diabetes)<br>(602) 344- 8478 (Transplants) | (602) 344-1224 |
| Hospice | (602) 344-8483<br>(602) 344-8825<br>(602) 344-8310 | (602) 344-8706 |
| Transportation/Non emergency ambulance | (602) 344-8300<br>(602) 344-8111 (After Hours) | (602) 344-8458 |
| Podiatry care in a skilled setting - Non-Medicare | (602) 344-8111 | (602) 344-8524 |
| Podiatry outpatient Care | (602) 344-8111 | (602) 344-8524 |
| Nutritional supplements | (602) 344-8483<br>(602) 344-8825<br>(602) 344-8310 | (602) 344-8706 |
| Pain Management | (602) 344-8483<br>(602) 344-8825<br>(602) 344-8310 | (602) 344-8706 |
| Seating Evaluations | (602) 344-8483<br>(602) 344-8825<br>(602) 344-8859 | (602) 344-8706 |
| Sleep Studies | (602) 344-8483<br>(602) 344-8825<br>(602) 344-8859 | (602) 344-8706 |
| Therapies: Pulmonary, Respiratory, Cardiac Rehab, OT, Speech, PT | (602) 344-8483<br>(602) 344-8825<br>(602) 344-8310 | (602) 344-8706 |
| Transplants or related care | (602) 344-8478 | (602) 344-8909 |

## Certificates of Medical Necessity

A Certificate of Medical Necessity (CMN) must accompany orders for DME, services, and supplies.

# Maricopa Senior Select Plan cont.

## Outside Service Request

An Outside Services Request (OSR) form will be required for some services. An example of an OSR is provided on page 5.8.

**In the course of arranging or providing services, you may be required to provide the following additional documentation:**

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|---|---|
| Durable Medical Equipment | A signed OSR, progress notes, and/or justification for the requested equipment, and a Certificate of Medical Necessity (CMN) may be required. |
| Supplies | A signed OSR is required |
| Hospice | A physician order may be required |
| Nursing Home Placement | One or more of the following may be requested:<br>Current History and Physical<br>Current medication and treatment orders<br>Current TB test\Chest X-ray<br>All problem lists<br>Lab results<br>Physician Progress Notes<br>Any consult or therapy evaluations<br>Immunization records |
| Therapy | A OSR may be requested |
| Specialty Providers | Information regarding the referral to the receiving provider |
| PCPs or Specialists | Information or reports back to the referring provider |
| All Providers | Communicate with all treating providers as needed when informed by Member of other treatment |

### Claims Submission

MSSP must process a clean claim within thirty (30) business days. A clean claim is one that contains all the elements necessary to process the claim. Claims must be submitted no later than December 31st of the following year from the date of service to be eligible for payment. Charges for professional fees must be submitted on a CMS 1500. Charges for inpatient or non-professional type services must be submitted on a UB92.

### Encounter Data & Reporting Requirements

Providers of service must ensure that encounter data and reporting requirements (including medical records) are complete and accurate. MSSP may peform a data validation study to determine utilization, accuracy, and completeness.

### Emergency & Urgent Care Services

CMS defines emergency and urgent care as follows:
Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the women or her unborn child
- Serious impairment to bodily function, or
- Serious dysfunction of any bodily organ or part

# Maricopa Senior Select Plan cont.

**Emergency services** means covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition

**Urgently needed services** means covered services provided when an enrollee is temporarily absent from the health plan service area (for a period of up to 6 months) when such services are medically necessary and immediately required

- As a result of an unforeseen illness injury or condition
- It was not reasonable given the circumstances to obtain the services through MSSP

**Note:** *MSSP is responsible for the cost of post stabilization care provided outside the plan, if the care was approved by MSSP. MSSP is also responsible if the care was not pre-approved, because MSSP did not respond to the post stabilization care provider's request for pre-approval within 1 hour after the request, or MSSP could not be contacted for pre-approval.* ***Post stabilization care*** *is medically necessary, non-emergent services needed to ensure that the member remains stabilized from the time that the treating hospital requests authorization from MSSP until the member is discharged, a plan physician arrives and assumes responsibility for the member's care, or the treating physician and the Plan agree to another arrangement.*

## Services Rendered by Non Contracted Providers for Dialysis

MSSP is required to assume financial responsibility for services provided by non-contracted providers when the member is temporarily outside of the MSSP service area (up to 6 months) for renal dialysis.

## Direct Access (through self-referral)

MSSP must allow direct access for the following services:

- Mammography
- Influenza vaccine and pnuemococcal vaccine (cost sharing is not required for these services)
- Women's routine and preventive health care services

# Maricopa Senior Select cont.

## Care Coordination

MSSP must ensure continuity of care and integration of services through arrangements that include, but are not limited to:

- Use of a practitioner specifically designated as having primary responsibilities for coordinating the member's overall health
- An ongoing source of primary care
- An initial assessment of each member's needs within ninety (90) days of the effective date of enrollment
- Each provider, supplier and practitioner maintains a member health record within MSSP standards

- MSSP will issue a Notice of Discharge and Medicare Appeal Rights (NODMAR) 24-hours prior to hospital discharge and a Skilled Nursing Facility notice 3 to 4 days prior to ending skilled care. These notices outline the member's right to appeal such a decision

## Prohibition on Interference with Advice from Health Care Professionals

MSSP may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising and/or advocating on behalf of a member about his/her health status, medical care, treatment options, risks, benefits, consequences of treatment/non-treatment or to provide the member an opportunity to refuse treatment or express preferences regarding future treatment.

## Appeals and Grievances

Providers do not have appeals and grievance rights under this plan. However, MIHS-HP contracted providers may participate in the process as an agent for the member. Members may initiate appeals and grievances in the event they do not agree with a determination made by the Health Plan.

| | |
|---|---|
| **Appeals** | Any of the procedures that deal with the review of organization determinations, including reconsiderations hearing before administrative law judges (ALJs), reviews by the Departmental Appeals Board (DAB) and judicial review (422) |
| **Grievances** | A Grievance is a more formal method used to resolve a members complaint that could<br>not be resolved to the member's satisfaction through the informal complaint resolution process, but does not involve a denial, reduction or termination of service |
| **Reconsideration** | A reconsideration consists of a review of an adverse organization determination (a decision that is unfavorable to the enrollee, in whole or in part) by either the health plan or an independent review entity. |

Please direct inquiries from members to the MIHS-HP Member Services Department at (602) 344-8760.

# Maricopa Senior Select Plan cont.

## Assessment/Treatment of MSSP Members w/Complex or Serious Medical Conditions

Primary Care Physicians (PCPs) or attending physicians during outpatient, emergency or inpatient care will develop a treatment plan in coordination with appropriate medical personnel, case mangers and/or MIHS-HP-MSSP case management staff. Treatment plans must be developed for members with the following conditions:

- AIDS
- Asthma
- Brain tumor
- Closed Head injuries
- Diabetes
- Leukemia
- Myocardial infarction
- Sickle cell disease
- Transplants
- Trauma i.e.: burn, amputations, spinal cord injuries
- Ventilator dependent members

MSSP members are to be informed of specific health care needs that require follow up and they are to receive an appropriate training in self care and other measures they may take to promote their own health. MMSP must have systems in place to address barriers to treatment. Treatment plans must be monitored on a periodic basis.

## Continued Access to Specialty Care

MSSP members have the right to maintain access to Specialists in the case of involuntary termination of a plan or a specialist. Specialists who have terminated voluntarily or involuntarily are referred by their PCP to another specialist within the MSSP network or to a non-contracted specialist arranged by MSSP when none is available.

## Medical Records

MIHS-HP providers and MSSP must safeguard the privacy of information that identifies a particular member. Information may be released to authorized persons only. In the case of a new MSO (Managed Services Organization) or PCP selection, medical records must be forwarded to the new PCP or MSO as soon as possible. Original medical records must only be released in accordance with Federal or State laws, court orders or subpoenas. Records must be maintained in an accurate and timely manner. Information regarding advance directives must be kept in a prominent place in the member's file. Clear and concise communication with the member in language that he/she understands regarding the risks, benefits and consequences of treatment or non-treatment, and the member's right to refuse treatment must all be documented in the member's file. Members and Providers must have timely access to records. Medical records must be maintained for at least six (6) years.

## Denials, Suspension and Terminations

MSSP must notify its delivery system at least sixty (60) days before implementation of any adverse action that would affect health care professionals and their ability to coordinate care. Examples include termination without cause, suspension of a provider's participation. Providers have the right to appeal such a determination and have the appeal heard before a panel of her/his peers. Providers terminated or suspended for quality deficiencies must be reported to the appropriate governing body.

# Maricopa Senior Select Plan cont.

## Prohibition Regarding Discrimination

MSSP and CMS require that all providers adhere to all laws regarding discrimination including Title VI of the Civil Rights Act of 1964, The Age Discrimination Act of 1975, the Americans with Disabilities Act and any laws applicable to recipients of Federal Funds. This very simply means that health care providers may not discriminate against members based on race, gender, age, or disability. Providers must agree to provide benefits in a manner consistent with professionally recognized standards of health care, all benefits covered by Medicare.

## Communication between Providers

MSSP expects that Providers will communicate with each other regarding the needs of its members in a timely fashion. This includes but is not limited to diagnostic results, treatment plans, social and economic factors that may or may not impact the treating physician's ability to care for his/her patient. Test results and other outcomes should be provided to the referring physician as well as the member's PCP as soon as possible. This communication should become a part of the patient's medical record.

## Communication with Members

MSSP expects that Providers will communicate with its members in a timely fashion regarding their medical care. Clear and concise communication with the member in language and manner that he/she understands regarding the risks, benefits and consequences of treatment or non-treatment, and the member's right to refuse treatment must be clearly communicated. This communication must be documented in the member's file.

## Members Rights and Responsibilities

- Members must have choice & timely access of a qualified Contracted Primary Care Physician including PCPs, Specialists and Emergency Care
- Members must have the right to be treated with dignity and respect and have the right to privacy
- Members must have the opportunity to engage in candid discussion of appropriate or Medically Necessary treatment options including active participation in the selection of treatment options.

- Members must provide physicians or other care providers the information necessary for treatment
- Members must follow treatment plans
- Members must behave in a manner that supports care provided to other patients and the general functioning of the facility
- Members must Accept responsibility for Co-payments or Coinsurance
- Members must review information regarding their benefits
- Members must ask questions of their Primary Care Physicians or MSSP regarding concerns related to treatment or financial issues.

# Maricopa Senior Select Plan cont.

**Plan Hospitals**

- Arrowhead Hospital
- Scottsdale Memorial Hospital - Osborne
- Scottsdale Memorial Hospital - Shea
- St. Joseph's
-Tempe St. Luke's Medical Center
-Wickenburg Regional Medical Center
- John C. Lincoln Deer Valley
- Maricopa Medical Center
- Maryvale Hospital
- Phoenix Baptist Hospital -
- Mesa General Hospital
- Chandler Regional
- John C. Lincoln North Mountain

**Plan Pharmacies**

Selected Fry's Pharmacies
Selected United Drugs
Selected Family Health Centers